DMA-460: 06-EOMB

TCN | | | | | | | | | | | | | | | | | |

DEPARTMENT OF COMMUNITY HEALTH - DIVISION OF MEDICAL ASSISTANCE
MEDICARE NOTIFICATION FORM

Member Name: _____ **Medicaid ID #:** _____

I. MEDICARE CO-PAYMENT NOTIFICATION

No EOMB/RA Available. Coverage is through _____
Medicare HMO plan. The co-payment for this service is _____.

II. MEDICARE NON-COVERAGE AFFIDAVIT

These services are not covered by Medicare Part A, Medicare Part B, or the Medicare HMO in which this member is enrolled.

_____Medicare Part A was terminated on _____
Date

_____Medicare Part B was terminated on _____
Date

_____Service is non-covered by Medicare;

_____Annual/lifetime service limits exceeded; and/or

_____Other (explain) _____

By signing, I certify that, to the best of my knowledge, the information above is verified and accurate, and that this notification form applies to any associated claim(s) and is made a part thereof.

_____ _____ _____
Signature of Patient Account Representative ***Date*** ***Provider #***

Note: This statement must be in accordance with the provisions of Part I, Policies and Procedures, Chapter 200 - Timely Submission, Section 202.2(b).

Attach this form to your claim(s) for paper claim submission, or if claim submitted electronically, indicate the associated TCN above and forward to GHP for processing.

III. MEDIGAP/MEDICARE SUPPLEMENTAL INSURANCE INFORMATION UPDATE

When a provider has knowledge that a member is enrolled in any other insurance or health benefit plan, other than Medicare and Medicaid, you are obligated to notify the Department of that coverage. You can do so by completing only this portion of the form. It may be faxed to GHP ATTN: COB Unit at 866-483-1044 or 866-483-1045 or mailed to GHP, Attn: COB Unit, PO Box 5000, McRae, GA 31055; If there are multiple cards, e.g., a medical card and a pharmacy card, complete separate forms or make copies of all cards (front & back) to submit with this form.

COORDINATION OF BENEFITS (COB) INFORMATION: ***Please complete in full or attach a copy of the insurance card(s), front and back.***

Policyholder: _____ **Pt. Relationship to Policyholder:** _____

Insurance Carrier: _____ **Policy #:** _____

Employer: _____ **Group #:** _____

Subscriber/Member ID #: _____ **Effective Date:** _____

Coverage Type(s): ***(Circle all that apply)*** **Medicare Part A Supplement** **Medicare Part B Supplement**
Pharmacy **Long Term Care** **Dental** **Vision**

Other: _____

THIS FORM MAY BE PHOTOCOPIED